County of San Bernardino

Access Unit
850 East Foothill Blvd. • Rialto, CA 92376 • (888) 743-1478 • Fax (909) 421-9272

CaSONYA THOMAS, MPA, CHC
Director

November 1, 2012

Dear Outpatient Fee-For-Service Provider:

The Department of Behavioral Health is happy to announce exciting changes for the new year, 2013. We have listened to your feedback from our recent FFS Provider Satisfaction Survey 11-12. As the result, we have developed and implemented a number of changes to how we process Treatment Authorization Requests (TAR).

The following changes can be anticipated to take effect as of **January 1, 2013**:

- A standardized 2-page Treatment Authorization Request (TAR) will be used for all routine authorization requests (i.e., MHP Assessment, Re-Authorization, Annual Review).
- Elimination of pre-authorization requests for mental health consultation in a medical-surgical hospital setting. Please note, this service is only applicable to Psychiatrist (MD/DO) and Psychologist (Psy.D./Ph.D).
- Standardize authorization cycles for outpatient psychotherapy services will increase from 4 months cycles to 6 months cycles. Please note, there is no change to the current authorization cycles for medication management.

We have attached detailed explanations to the above changes for your review. Please note that the new 2-page TAR and all of these updates are available on our FFS Provider website (see attached flyer to access the website).

Please do not hesitate to contact the Access Unit if you have any questions. Please note that this is only for FFS Providers currently in "Active" status.

Sincerely,

Al Evans
Administrative Supervisor II, Access Unit
Department of Behavioral Health

County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH

Fee-For-Service Providers

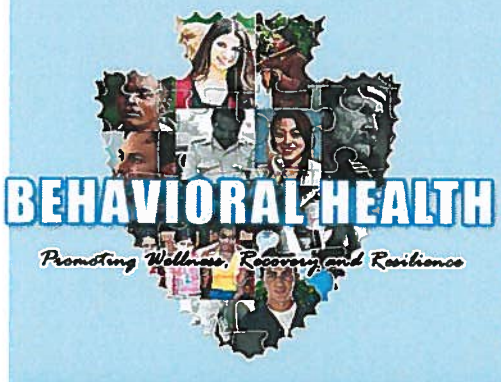
DID YOU KNOW?

NEW for 2013:
2-page Treatment Authorization Request (TAR) form

This form replaces all routine TAR forms including: the 6-page MHP Assessment Form, the Annual Review Form, and the Re-Authorization of Services Form.

*The new 2-page TAR has been designed to target the essential information needed to determine **medical necessity**. Particular attention has been given to the following:*

- *Creation of a user friendly, check-off type format*
- *Minimize information redundancy*
- *Reduce paperwork volume*
- *Consolidate request for authorization forms to eliminate confusion over which form to complete*



PLEASE NOTE: beneficiary signatures are not required on the new 2-page TAR. The TAR is intended to be used for authorization purposes. It is not intended as a replacement for clinical records. Please refer to FFS Provider

For questions and concerns please contact the **Access Unit** at **(888) 743-1478 or (909) 381-2420** and ask to speak to Provider Relations or visit our website: www.sbcounty.gov/

San Bernardino County Department of Behavioral Health

Fee-For-Service Provider- Outpatient Treatment Authorization Request (TAR)

All items must be addressed. Approval is based on documentation of Medical Necessity (Functional Impairments)

PART 1	BENEFICIARY INFORMATION				
Client Name				DOB	
Phone		SSN or Medi-Cal Number			
Address		City & Zip Code			
Living Arrangement	☐ Independent ☐ Bio Family ☐ Foster Family ☐ Group Home ☐ SNF ☐ B&C				
Minor is under the jurisdiction of:	☐ DCS ☐ Court ☐ Probation ☐ Bio Family ☐ Other				

PART 2	PROVIDER INFORMATION				
Provider Name					
Provider Service Site Address		City & Zip Code			
Phone # ( )	Fax # ( )	Licensure	☐Psychiatrist	☐Psychologist	☐ LCSW ☐ LMFT

PART 3	TREATMENT AUTHORIZATION REQUESTED *(check all that apply)*		
☐ Adult ☐Minor CFS Active ☐ Yes ☐ No	☐Initial Authorization Assessment Date __/__/____ *(for claims)*	☐Re-Authorization ☐Changes to Authorization	**Received Date Stamp** *(County Use Only):*
Coordination of Care with	☐PCP ☐Psychiatrist ☐Psychologist ☐ LCSW ☐ LMFT ☐ DCFS ☐Other		
Modality & Requested Units *(For Psychologist, LCSW, LMFT)*	☐ Individual ___ ☐Family__ ☐Case Conference___ ☐Group___ ***Authorizations are for 6 months cycles.***		
Modality & Requested Units *(For Psychiatrist)*	☐ Pharmacological Management *___ ***Authorizations for minors are for 6 months cycles.*** ***Authorizations for adults are for 12 months.***	***NOTE: Signed Medication Consent Form MUST be attached for Initial Requests.**	

PART 4	MEDICAL NECESSITY						
Current Presenting Problem: (*Clinical Symptoms and Behaviors)*							
Mental Status	**Appearance**	☐Clean	☐ Groomed	☐Dirty	☐Disheveled		
	Speech	☐Organized	☐Coherent	☐Pressured	☐Rapid	☐Slow	☐Mumbling
	Orientation	☐Person	☐Place	☐Time	☐Situation		
	Affect	☐Appropriate	☐Blunted/Flat	☐Restricted	☐Labile	☐Tearful	
	Insight	☐Good	☐Average	☐Poor	☐None		
	Judgment	☐Good	☐Average	☐Poor	☐None		
	Mood	☐Stable	☐Depressed	☐Irritable	☐Anxious	☐Manic	☐Elevated
	Perception	☐Normal	☐Auditory Hallucinations		☐Visual Hallucinations		☐Other_____
	Thought Content	☐Normal	☐Delusional	☐Grandiose	☐Paranoid	☐Phobic	☐Other_____
	Thought Process	☐Organized	☐Poor Concentration	☐Obsessive	☐Flight of Ideas	☐ Thought Blocking	
Risk Assessments	**Suicidal Ideation**	☐None ☐Ideation ☐Intent ☐Plan ☐Means ☐History Describe:					
	Homicidal Ideation	☐None ☐Ideation ☐Intent ☐Plan ☐Means ☐History Describe:					
Prior Inpatient Psychiatric Admissions	☐**None** ☐**Yes (# last year)____**	**Other Outpatient Mental Health Services**	☐**None** ☐ **Yes _____**				

Medical Conditions	**Health Problems**	☐ None	☐ Yes / Describe:			
	Sleep Problems	☐ None	☐ Yes / Describe:			
	Appetite Changes	☐ None	☐ Yes / Describe:			
	Adverse Response to Medication	☐ None	☐ Yes / Describe:			
	Height / Weight *(required for minors)*	**Height Changes**		**Weight (lbs) Changes**		

Current Medication	Name	Dose	Frequency	Target Symptoms

Past Medications	

CURRENT DIAGNOSIS

Axis	Code	Name *(please make sure name matches with the code reported)*
I		
II		
III		
IV	☐ *Primary Support* ☐ *Social Environment* ☐ *Educational* ☐ *Occupational* ☐ *Housing* ☐ *Economic* ☐ *Legal* ☐ *Access to Health Care Services* ☐ Other/Specify	
V	**GAF Score**	

Impairment Criteria *(minimum one due to the documented Axis I diagnosis)*	☐ A significant impairment in an important area of life functioning. ☐ A probability of significant deterioration in an important area of life functioning. ☐ A probability that the client will not progress developmentally as individually appropriate. ☐ For EPSDT beneficiaries, a condition due to a mental disorder that specialty mental health services can improve.
Intervention Criteria *(must have 1,2, and 3 or 3 and 4)*	☐ **1.** The focus of treatment is to address the condition identified in the impairment criteria. ☐ **2.** The proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning or allow the client to progress developmentally as individually appropriate. ☐ **3.** The condition would not be responsive to physical health care based treatment. ☐ **4.** For EPSDT beneficiaries, a condition due to a mental disorder that specialty mental health services can improve.

PART 5	**PROVIDER NAME & SIGNATURE** (I certify that the above information is accurate and all the eligibility documentation required are on file)			
Provider Name		Provider Signature		Date

FAX COMPLETED FORM TO COUNTY OF SAN BERNARDINO ACCESS UNIT AT (909) 421-9272.
Authorization requests are processed within 14 calendar days from date this completed TAR is received by the unit.

PART 6	**MHP ACTION: (COUNTY USE ONLY)**			
☐ **Unable to Process**	☐ Missing required information ☐ Unable to locate beneficiary ☐ Duplication of services ☐ Other:			
Action	☐ Approved (*Authorization letter sent*) ☐ 14 Calendar Days Extension Request Made Extension to: __/__/____ =*28 days from original stamp date*	☐ Modified ☐ Denied	☐ NOA-B Issued __/__/____	☐**Provider Notified**__/__/____ ☐**Beneficiary Notified**__/__/____
Reason for 14 Days Extension or Comments				
Access Unit Reviewer Name		Signature		
Reviewer Title / License		Date		

County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH

Fee-For-Service Psychiatrist & Psychologist

DID YOU KNOW?

***Pre-Authorization for Medical-Surgical Consultation Request* are <u>no longer required</u>**

*As of **10-1-2012**, providers will no longer need to submit a pre-authorization request for the provision of Mental Health Consultations in a Medical-Surgical Hospital Setting. Please use **<u>CPT-code 90801</u>** for all consultations, even for a follow up mental health consultation in the same setting.*

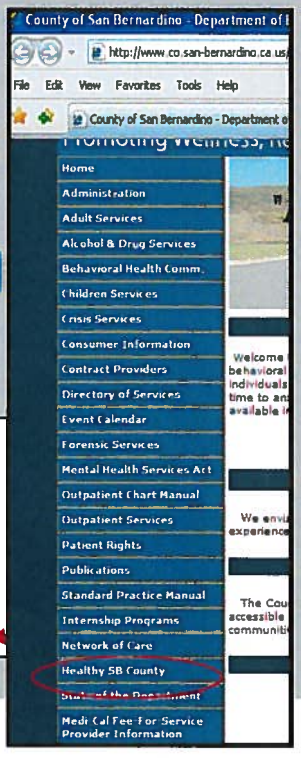
For questions and concerns please contact the **Access Unit** at **(888) 743-1478 or (909) 381-2420** and ask to speak with Provider Relations.

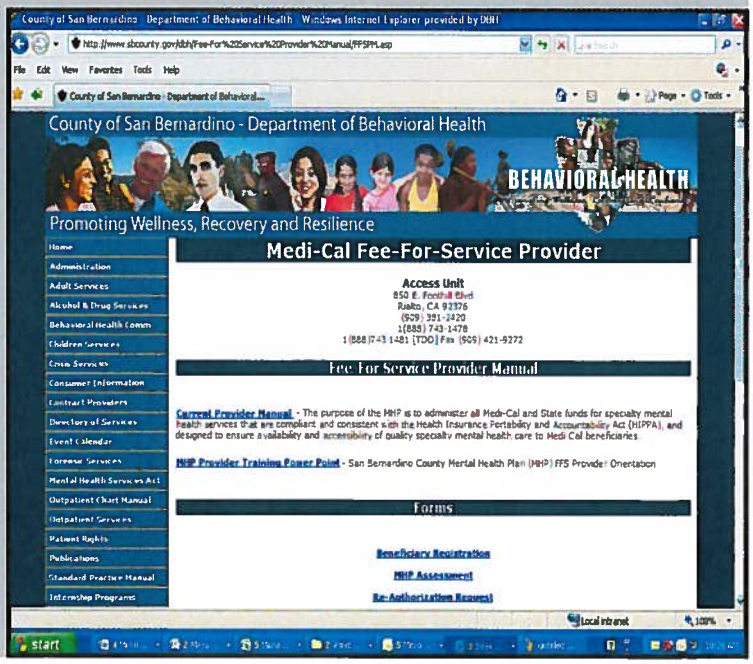
Or Simply go to the FFS Provider Webpage located at <u>www.sbcounty.gov/dbh</u>

BEHAVIORAL HEALTH

Promoting Wellness, Recovery and Resilience

Click on Medi-Cal Fee-For-Service Provider Information on the left sidebar.





County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH

Fee-For-Service Providers

DID YOU KNOW?

All Authorization Forms, Provider Manual, and Provider Updates can be accessed online via our website

** Please continue to submit the **completed** documents via fax to (909) 421-9272.*

For questions and concerns please contact the **Access Unit** at **(888) 743-1478 or (909) 381-2420** and ask to speak with Provider Relations.

Simply go to the DBH Home Page at www.sbcounty.gov/dbh

Click on Medi-Cal Fee-For-Service Provider Information on the left sidebar.

Forms are located here under the forms header.